



Making CAM Auditable

Technologies of Assurance in CAM Practice Today

Wahlberg, Ayo

Published in:
Routledge Handbook of Complementary and Alternative Medicine

Publication date:
2015

Document version
Early version, also known as pre-print

Citation for published version (APA):
Wahlberg, A. (2015). Making CAM Auditable: Technologies of Assurance in CAM Practice Today. In N. Gale, & J. McHale (Eds.), *Routledge Handbook of Complementary and Alternative Medicine: Perspectives from Social Science and Law* (pp. 129-143). Routledge. <http://www.routledge.com/books/details/9780415818940/>

Making CAM auditable – technologies of assurance in CAM practice today

Ayo Wahlberg, Associate Professor, Department of Anthropology, University of Copenhagen

Introduction

The principal purpose of regulation of any healthcare profession is to protect the public from unqualified or inadequately trained practitioners. The effective regulation of a therapy thus allows the public to understand where to look in order to get safe treatment from well-trained practitioners in an environment where their rights are protected. It also underpins the healthcare professions' confidence in a therapy's practitioners and is therefore fundamental in the development of all healthcare professions... High quality, accredited training of practitioners in the principal CAM disciplines is vital in ensuring that the public are protected from incompetent and dangerous practitioners.

House of Lords 2000: 5.1; 6.1

Whether CAM is dangerous or not has been and remains a contentious matter among CAM practitioners, medical doctors, regulators and patients alike. For some, all CAM (however defined) is dangerous, "like bringing back bleeding with leeches... developed before we understood the causes of disease, before germ theory" (Dawkins cited in Clements 2007). For others, it is those CAMs that "lack any credible evidence base" (House of Lords 2000: 2.1), located at the bottom of safety-efficacy hierarchies that are dangerous (if only because their use can delay credible treatment). And still others see CAM as exactly an antidote to the dangers of modern medicine, "a kinder alternative to mainstream medicine [providing] a safe, gentle and effective approach to health care" (NIMH 2004).

In this paper, rather than approaching the regulation of CAM as an arena of competing interests, boundary building and gate-keeping (cf. Saks 1995, 2003; Cant and Sharma 1996; Welsh et al. 2004; Cohen 1998), I will approach CAM as a problematic of government, which is to say as an assemblage of "assorted attempts at the calculated administration of diverse aspects of conduct through countless, often competing, local tactics of education, persuasion, inducement, management, incitement, motivation and encouragement" (Rose and Miller 1992: 175). My

analysis will focus on regulatory developments surrounding CAM in the United Kingdom over the last three decades or so as various CAM therapies have debated, adopted, rejected or been denied statutory regulation, with many opting for voluntary self-regulation.

Debates around the regulation of CAM practitioners, both generally and within different CAM therapies have been polemic to say the least: “allowing this bizarre pseudo-regulation to continue risks legitimising a whole range of bogus medical practices” (Robbins 2010); “State regulation does not ensure the public’s safety... and results in considerable amounts of time and tax payer’s money being wasted” (Save Our Herbs 2012); “The state is attempting to impose Statutory Regulation on herbalists under the pretext of ‘protecting the public’ without providing a scrap of evidence that we have ever posed a risk” (Herbarium 2009); “regulation is the best way to safeguard the public” (ATCM 2010). Whatever positions there may be, it is clear that CAM in the UK is in a regulatory moment as an on-going process involving Ministries, government agencies, CAM organisations, practitioners and others unfolds.¹ Indeed the task of this paper is not to determine what form of regulation is most appropriate or suitable for CAM, or indeed whether it is appropriate to regulate CAM, rather it is to examine the conditions of possibility of CAM’s regulatory moment – how is it that CAM practice today is something that must be regulated rather than actively marginalised or prohibited as a matter of public protection?

There are three key arguments I will be making to shed light on this regulatory moment. Firstly, I will argue that once CAM in the UK was, in a sense, welcomed ‘into the fold’ somewhere around the early 1990s (however contentiously), it became amenable to the kind of ‘audit society’ or ‘audit culture’ whose origins Michael Power (1999), Marilyn Strathern (2000), Cris Shore and Susan Wright (1999) have traced to exactly the same period. Moreover, calls to regulate CAM have also come at a time when the biomedical profession itself has been under increasing pressure to improve the auditing of its members in the wake of series of high profile scandals. Medical practice, whether orthodox or unorthodox, must be accountable. Secondly, I will argue that since the early 1990s ‘the Council’ has emerged as a central *dispositif* or grid for CAM through which the ‘competent and responsible practitioner’ comes to be made up and managed as a counterpoint to

¹ In this paper I will be focusing on the regulation of CAM practice and will not be discussing the regulation of CAM products which is an equally important aspect of CAM regulation.

the 'incompetent and dangerous practitioner' identified by regulatory authorities as a hazard to the public's health. The task of Councils is to oversee, certify, sanction and discipline in a way that is visible to members of the public. Finally, I will argue that the Council as *dispositif* operates through what might be termed *technologies of assurance* – understood as an assemblage of strategies, techniques, institutions and problematisations through which certain activities and/or actions come to be vouched for over others. In this particular case, it is the ethical and professional competence of certain individuals that is to be vouched for over others as practitioner associations are called upon to police their own members through the formulation of codes of ethics and practice, the accreditation of CAM teaching courses, the definition of dishonourable conduct and professional and ethical misconduct, the establishing of ethics committees, as well as through the implementation of disciplinary and complaints procedures as a way to 'censure, suspend or expel' members if deemed necessary.

To make these arguments I will trace CAM regulation as it has unfolded in and between five particular arenas. Firstly, the House of Lords has been particularly instrumental in debating and making recommendations about the regulation of CAM, especially after it organised a series of debates on Natural Medicine in the 1980s and culminating in the publication of a Select Committee report on Complementary and Alternative Medicine in 2000. Tracing CAM debates in the House of Lords can give us a sense of how a regulatory imperative has emerged around CAM. Secondly, the British Medical Association (BMA) as a representative of the UK's biomedical profession has often been a vocal critic of CAM practice, while at the same time serving as a model for other CAM associations. As we will see, the BMA has changed its tactics towards CAM considerably over the last decades. Thirdly, since the 1990s, a series of Associations and Regulatory Working Groups have been formed around various forms of CAM with a remit to propose an appropriate form of regulation for their profession. Such working groups often consist of representatives from different and sometimes competing CAM groupings. The formation and activities of working groups have been particularly divisive as different views on the most appropriate form of regulation for a therapy circulate. Fourthly, as the responsible agency for implementing and overseeing regulation of medical professions in the United Kingdom, the Department of Health has stepped up efforts to regulate CAM especially in the aftermath of the

House of Lords Select Committee report which recommended regulation of some forms of CAM. Finally, a number of non-governmental organisations and individuals have contributed to regulatory discussions by publishing reports, establishing websites or through the media. It is the assorted attempts at the calculated administration of CAM conduct currently playing out within these arenas that I will analyse in the following.

“They must put their own house in order” – confusion in the CAM marketplace

Ever since the ‘Act to regulate the qualifications of practitioners in medicine and surgery’ came into force in 1858, one of the central objectives of UK statutory medical regulation has been to enable “Persons requiring Medical Aid... to distinguish qualified from unqualified Practitioners” (Great Britain Parliament 1858). Although a number of CAM therapies have a long history of organisation and self-regulation in the United Kingdom, it was not until 1986 that a series of state-supported efforts aimed at helping the public to know where to look for safe and competent CAM treatment would be set in motion (Wahlberg 2007) (see box 1). It was in this year that the Board of Science of the British Medical Association published its report on *Alternative Therapy* (BMA 1986). The report had been commissioned by the Prince of Wales, an advocate of CAM, while he was President of the BMA in the early 1980s. Yet when published, the report was read by many as an attack on CAM.² Reacting to the report, Harold Wicks of the Research Council for Complementary Medicine suggested that “by being negative and dismissive the report will separate the orthodox from the complementary practitioner. That is not in the public interest.” (cited in Veitch 1986). Nonetheless, chairman of the Board of Science of the BMA Professor James Paine did hint that regulation might be the way forward for some therapies: “The ordinary citizen is in no position to decide whether an acupuncturist has been trained or whether he has been off on a weekend course and come back with an armful of needles” (ibid.).

It was exactly this problem of knowing where to look that was again highlighted by the chair of the British Complementary Medicine Association (BCMA) at its launch a few years later in June 1992:

² On the 13th of May 1986 the Guardian ran the story “BMA’s wounding verdict on rival healers / Alternative medicine dismissed as ineffective” (Veitch 1986) while the Times ran with “Doctors warn patients of risk from some alternative medicines” (Timmins 1986).

“The position of the consumer is one of confusion and vulnerability at present; where else can you be a consultant overnight except in alternative therapy?” (cited in Westcott 1992: 19). Eight years later, the House of Lords Select Committee’s report on CAM concurred, arguing that lack of regulation “inevitably, gave rise to considerable public confusion amongst members of the public” and consequently that “the effective regulation of a [CAM] therapy... allows the public to understand where to look in order to get safe treatment from well-trained practitioners” (House of Lords 2000: 5.12, 5.1). And more recently, the Affiliation of Crystal Healing Organisations has referred to “national concerns... mainly centred around the safety of the public and how they can distinguish between a well-trained practitioner and people who have only taken a short course” (ACHO 2012).

And so we can see, how the lack of a regulated CAM field came to be framed as a political problem of public protection. So, how is it that the mid-1980s marked a tactical turning point when it came to protecting the public? Part of the answer is undoubtedly to be found in the question put by Lord Prys-Davies to his peers during a House of Lords debate on Natural Medicine on the 27th of February 1985: “why has a trickle of interest in alternative medicine become, in recent years, a flood?” (House of Lords 1985: 985) Like in many other countries, policymakers in the UK were coming to terms with what the BMA called a “growing interest” in CAM during the 1980s. If there indeed was a flood of patients consulting CAM practitioners, just what kind of a marketplace was it they were entering? Lord Winstanley gave his frank assessment in the same House of Lords debate:

Here in Britain nearly all these professions (if that is the right word) of alternative medicine are at present in an uncontrolled state, similar to the uncontrolled state of the estate agents. For years and years, in your Lordships' House and in another place, Members have been talking about the need for some kind of regulation of the estate agents. It cannot be done until they put their own house in order. The same applies to some of the practitioners who have real skills and real ability. But they, too, collectively, must put their own house in order. Until their ranks are organised and their people are trained and registered, they cannot really be let in, if I may use that phrase, if the public are to be protected against fraud, exploitation and incompetence. (House of Lords 1985: 975)

The decades that have followed might well be described as a more or less concerted effort to put the ‘CAM house in order’. The first challenge facing CAM practitioners has been what the House of Lords Select Committee described as “considerable fragmentation, sometimes resulting in several

bodies, each with different training and educational requirements, codes of practice and complaints procedures, representing therapists in the same field” (House of Lords 2000: 5.11). In its response to the House of Lords report the Department of Health decried such a state of affairs: “stakeholders clearly deserve better than the current fragmented regulation of certain CAM therapies. The Government therefore strongly encourages the regulating bodies within each therapy to unite to form a single body to regulate each profession” (DoH 2001: 7).

Looking at the last twenty years, regulatory authorities have begun ranking different forms of CAM according to their regulatory maturity. In such accounts a regulatory continuum is invoked beginning with the formation of affiliations and associations of CAM practitioners such as the Affiliation of Crystal Healing Organisations, the British Complementary Medicine Association or the Aromatherapy Council. The next stage is when CAM practitioners bring fragmented organisations together to form regulatory working groups, such as the Herbal Medicine Regulatory Working Group, the Acupuncture Regulatory Working Group, the Reiki Regulatory Working Group or the Working Group for Hypnotherapy Regulation. The task facing such working groups is to decide upon a regulatory model suitable for their therapy, a task that has proven divisive. CAM therapies can choose between maintaining status quo, pursuing a path of statutory regulation or opting for voluntary self-regulation. Chiropractors and osteopaths were the first to pursue and achieve statutory regulation in 1993 and 1994 respectively, leading to the formation of the General Chiropractic Council and the General Osteopathic Council. Next in line, not least after they were singled out in the Select Committee report on CAM as the “two therapies which are at a stage where it would be of benefit to them and their patients if the practitioners strive for statutory regulation” (House of Lords 2000: 5.53), are herbal medicine and acupuncture (together with traditional Chinese medicine since TCM practitioners use both forms of CAM) although it is unclear yet whether they will fall under the remit of the Health Professions Council (HPC) or some other form of Council. The HPC is an umbrella council which regulates 17 different health and care professions. Most recently, the General Regulatory Council for Complementary Therapies (in 2007) and the Complementary and Natural Healthcare Council (in 2008) have been formed to regulate therapies like Alexander Technique, Aromatherapy, Bowen Therapy, Craniosacral Therapy, Reflexology and Healing.

The process remains on-going and both the Department of Health and the Prince of Wales Foundation for Integrated Health (FIH) have suggested we can speak of “the stage various therapies have reached in their professional organisation” (DoH 2001: 4) or the “different stages of developing voluntary systems of regulation” (PWFIH, 2005, p. 13). But the process has, as noted earlier, also been divisive for many practitioners of CAM, leading some to resign from their practitioner associations in protest while others passionately advocate specific forms of regulation. Within herbal medicine, for example, a drive towards statutory regulation by some herbal practitioners has been disparaged by others (see Griggs 1997; Save Our Herbs 2012).

Each Council, Affiliation or Working Group has had a particular history involving forms of negotiation, bureaucratic hurdles, factions, lobbying, etc. not least vis-à-vis regulatory agencies like the Department of Health, National Institute for Clinical Excellence, Medicines and Healthcare Products Regulatory Agency and National Health Service. Particularities notwithstanding, we can nonetheless point to a common point of departure for each of these diverse groupings, namely an impetus (whether imposed or generated from within) to overcome fragmentation and confusion; to help the public know where to look.

And so, the drive to regulate CAM which began in the late 1980s marks a significant shift in government-led efforts to protect the public. As put by Health Minister John Hutton in 2004, “It is no longer appropriate for statutory regulation to be restricted to orthodox healthcare professionals such as doctors, nurses and physiotherapists” (DoH 2004: 3). Regulating CAM as a matter of protecting the public is premised on the possibility of determining what a competent, skilled and responsible CAM practitioner is. And it is this acceptance that has been attacked by a vocal group of critics who argue that regulating CAM is akin to legitimising superstition: “you cannot start to think about a sensible form of regulation unless you first decide whether or not the thing you are trying to regulate is nonsense” (Colquhoun 2009); “How does a regulator decide what is good practice and what is charlatanry when none of it has peer-reviewed, scientific evidence that it works?” (Toynbee 2008). But for now, their protests have not seemed to dent the regulatory momentum around CAM accounted for above. One key reason for this is to be found in the resulting novel regulatory separation of ethical and professional practice from the highly

contentious question of efficacy. In a recent reply to a letter from one of the vocal critics of CAM regulation, a Department of Health representative suggested that:

Professional regulation, whether statutory or in this case, voluntary, is about protecting the public, not about the efficacy of the therapies involved. Registration will mean that a practitioner has met certain entry standards (for instance, has an accredited qualification) and subscribes to a set of professional standards. In this way, the public will have the reassurance that any registered practitioner they choose meets these criteria and that practitioners would be subject to fitness to practise procedures should they behave inappropriately. (cited in Thinking is Dangerous 2009)

Official recognition of such a thing as a “qualified CAM practitioner” has been central to the CAM regulatory moment. For, once invited to reassure members of the public through a system of qualification, CAM therapies are in effect a part of accepted health care provision. And as we will see in the following, once accepted CAM practitioners are expected to take active measures to assure people that they are fit to practice.

“Anyone could set themselves up tomorrow as a practitioner” – separating the wheat from the chaff

Now if CAM practitioners are in fact currently in the process of being ‘let in’, then we must account not only for this novel rationality of public protection – i.e. to regulate rather than actively marginalise or prohibit CAM – that has made space for the figure of the ‘ethically responsible and competent CAM practitioner’ but also for the particular configuration this political rationality has taken. The Council, I argue, has emerged not so much as a model, but rather as a central *dispositif* in the regulation of CAM; a grid through which ethically responsible and competent CAM practitioners are made up and managed. It was Foucault who proposed that a *dispositif* can be thought of as “a thoroughly heterogenous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions... The apparatus itself is the system of relations that can be established between these elements” (Foucault 1980: 194). The Council, as we will see, is the apparatus that has emerged through three decades of parliamentary debates, regulatory decisions, administrative measures, institutions, etc. surrounding CAM.

When we look at the series of state-sanctioned regulatory initiatives around CAM in the UK we should not be surprised to learn that they have been contemporaneous with what Michael Power has called an 'audit explosion':

During the late 1980s and early 1990s, the word 'audit' began to be used in Britain with growing frequency in a wide variety of contexts. In addition to the regulation of private company accounting by financial audit, practices of environmental audit, value for money audit, management audit, forensic audit, data audit, intellectual property audit, medical audit, teaching audit, and technology audit emerged and, to varying degrees, acquired a degree of institutional stability and acceptance. (Power 1999: 3)

For, we can surely add CAM audit to this list. Indeed, referring to the work initiated by the Council for Complementary and Alternative Medicine already in 1985, Lord Kindersley argued in a House of Lords debate on complementary medicine held on the 11th of November 1987 that:

different groups within complementary medicine have recently taken it upon themselves to establish an independent audit of their existing colleges and training centres with the aim of raising all to an acceptable level. As each group achieves this target within their own register, I hope that Parliament will give statutory recognition to the standards achieved. In this process it will be vitally important that those skilled practitioners of many years' experience do not find themselves left out in the cold. (House of Lords 1987: 1382)

If an initial strategy for helping the public to know where to look has been to overcome the confusion of fragmentation by encouraging unification of CAM therapies into single institutions, then an equally important task has been that of helping the public on an individual basis to distinguish the competent and responsible from the incompetent and unscrupulous ones. The task is twofold: on the one hand, one needs to ensure that practitioners are qualified (i.e. professionally competent) and on the other that they are responsible (i.e. ethically competent). In the UK, common law allows anyone to practice CAM as long as they do not falsely claim a statutorily protected title (e.g. osteopath and chiropractor are protected by law), dispense prescription medications or carry out certain invasive procedures that are limited by law to particular professions. Since the practice of most CAM therapies does not involve transgressing any of these statutory restrictions, it is not immediately clear how a member of the public would be able to distinguish between a qualified and an unqualified CAM practitioner (except in osteopathy and chiropractic), a situation that a number of CAM practitioners and others have been unsatisfied with:

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It's absurd – and dangerous too – that [anyone] could set themselves up tomorrow as a practitioner of herbal medicine. They could gain access to powerful herbs such as belladonna and ephedra, and give those to patients without any training or quality control at all. That has to stop. (Michael Dixon cited in Adams 2009)

This, then is where the Council as *dispositif* comes in as an apparatus of assurance. In July 2006, the Chief Medical Officer of the UK proposed “to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients [so that] patients, the public, the medical profession, employers and other contracting organisations become able to trust that every doctor will deliver good clinical care throughout their careers” (DoH 2006: vi). While the CMO's report was directed at the biomedical profession following a series of high profile scandals involving doctors who were deemed unfit to practice, the proposed emphasis on assurance and trust is just as relevant, if not more so bearing in mind on-going controversy, in the field of CAM regulation.

As argued by the Reflexology Forum, one of the main organisations representing reflexologists in the UK, “Whenever you see a Reflexologist you need to feel confident that the person treating you meets professional standards. You also need to know that someone will take action if things go wrong. That is where regulation is important.” (Reflexology Forum 2012) Similarly, one of the acupuncturists responding to the government's consultation on statutory regulation for herbal medicine and acupuncture suggested that once statutorily regulated through a Council “the public can be assured that any acupuncturist that they choose to visit fulfils the minimum criteria of competence required by the regulatory body” (DoH 2011: 12). The UK-based International Federation of Reflexologists agrees, suggesting that assurance and accountability are at the heart of what the newly established General Regulatory Council for Complementary Therapies stands for: “If a patient/client or a member of the medical profession calls a GRCCT registered therapist they can be reasonably assured that he/she is properly trained, insured and accountable for their actions” (IFR 2012).

It is in this sense that CAM regulation has come to take the form of the audit. Bearing in mind the complexities of modern ‘audit societies’, individuals have, in a sense, outsourced verification to other agencies. Michael Power and Marilyn Strathern both note, by recourse to Mary Douglas, how “people are constantly checking up on each other, constantly monitoring the ongoing stream of communicative exchanges and accounts that make up daily life” (Power 1999: 1) as

“accountability is part of the general fabric of human interchange” (Strathern 2000: 4). Yet in the bustle of complex urban life where individuals rarely have personal relations with the people providing them with goods and services (including medical services) the quality marks, kite marks, certifications and labels that audit processes can culminate in have become proxies or vouchers for that which is good, proper, correct and therefore trustworthy. This is exactly what is currently happening within the CAM field. The public, it is argued, are to feel confident that when they choose a certified CAM practitioner, she or he is both ‘fit to practice’ and ‘ethically responsible’. Thus, it is not up to the individual to laboriously separate the wheat from the chaff each time he or she would like to consult a CAM practitioner, instead rituals of verification are being put into place on their behalf.

As we will see in the following section, the Council has become the locus of such rituals of verification. The Council oversees, certifies, adjudicates, sanctions and disciplines as a matter of assurance and through a series of procedures and practices. If not anyone should be allowed to set themselves as a CAM practitioner, then criteria as well as procedures for checking these are needed to decide who it is that should be allowed to do so.

“It is the incompetent and the irresponsible we need to stop” – certification and sanctioning of CAM practice

In this final section of the paper, I will turn my attention to just how various CAM therapies have internalised the very dividing practices that at one time kept them from playing an active part in the delivery of health care in the UK (see Saks 1995; Brown 1982, 1985; Wallis and Morley 1976; Wahlberg 2007). To be sure, a number of CAM therapies in the UK have very long histories of self organisation which has involved the development of education programmes as well as policing of members’ practice (see Wahlberg 2010). However, as we have seen, it was not until the 1980s that such activities would gain any kind of official sanctioning from the state. What is more, as we will see, it is safe to say that there has been a significant intensification of efforts to ensure that CAM practitioners are competent and responsible in the past decade or so.

How then can one ensure that CAM practitioners are competent and responsible? In an 'audit society' like the UK's this task has revolved around making CAM practice auditable, which is to say making CAM practice amenable to measurement, verification and validation. As Michael Power notes, "a new market for assurance services has emerged which demands a tight coupling between quality performance, however that is to be defined, and processes to ensure that this performance is visible to a wider audience" (Power 1999: 60). It is within this market for assurance services that the General Osteopathic Council, the General Chiropractic Council, the Health Professions Council, the General Regulatory Council for Complementary Therapies and the Complementary and Natural Healthcare Council have emerged as they work to make CAM practice auditable. About such processes, Strathern argues:

Where audit is applied to public institutions—medical, legal, educational—the state's overt concern may be less to impose day-to-day direction than to ensure that internal controls, in the form of monitoring techniques, are in place. That may require the setting up of mechanisms where none existed before, but the accompanying rhetoric is likely to be that of helping (monitoring) people help (monitor) themselves, including helping people get used to this new 'culture'. (Strathern 2000: 3-4).

Let us take a closer look at how the various CAM councils are currently setting up monitoring mechanisms. The first point to be made about Councils and the technologies of assurance that they are built up around, is that they make no guarantees. Indeed this is one of the arguments made by opponents of statutory regulation:

The UK government is of the opinion that statutory regulation of Herbalists will protect the public from serious harm. However, has statutory regulation of the NHS, Banking and Pension industries protected the public? No, it most certainly has not! Even now, after so called "improved" guidelines resulting from the behaviour of Harold Shipman, abuse and cruelty on the part of medical staff is still being reported. (Save Our Herbs 2012)

What the setting up of a Council does instead is provide assurance by *vouching* for the professional and ethical competence of registered members as a matter of public protection. As the reflexologists quoted earlier put it, choosing a certified practitioner means that you "can be reasonably assured [that your practitioner] is properly trained, insured and accountable for their actions". What this means is that there are *systems* in place to check that a practitioner is qualified as well as to respond when something goes wrong. While each therapy is currently in the process of developing and refining its regulatory procedures, we can point to a range of common features of the systems that are currently being set up which relate to certification (i.e. recognised entry

into a particular CAM therapy) on the one hand, and punishing (i.e. suspension or expulsion from that therapy) on the other.

Accreditation and registration

One of the foremost tasks of a Council is to establish and maintain a register of competent practitioners. It is this act of gatekeeping that is aimed at providing the public with confidence in a specific therapy, as it is only qualified practitioners who will be allowed to register and conversely anyone deemed not qualified will be excluded. To operate a register, two important kinds of audits are required. Firstly, an audit of the schools or colleges that provide a CAM degree, and secondly an audit of the person who applies for membership in a Council's register. Accreditation is the form of the audit of CAM degrees. The General Chiropractic Council for example has developed a set of "Degree Recognition Criteria", the Herbal Medicine Regulatory Working Group has proposed an "Accreditation Handbook" and the Aromatherapy Council has developed a "Core Curriculum". Each specifies the criteria required to become an accredited provider of a degree which is then recognised by the respective Council. In recent years, a number of universities in the United Kingdom have begun offering degrees in, for example, acupuncture, aromatherapy, homeopathy, Ayurvedic medicine and Chinese herbal medicine. And not without controversy:

What would you think if your child went off to university to be taught that amethyst crystals "emit high yin energy"?... For more than a decade, "facts" such as these have been peddled by more than a dozen fully accredited, state-funded British universities... Indeed, since the mid-1990s, such ideas have been presented and taught as if they were real medicine... It may seem harmless and even a welcome alternative to traditional perspectives. But teaching people that homoeopathy is evidence-based when it isn't, and encouraging students to distrust the scientific method, not only runs counter to reason, but can be dangerous. (Colquhoun 2012)

Those critics who have dismissed regulation of CAM as nonsense have also argued that accreditation is dangerous. Yet this is exactly what all forms of CAM therapy are being encouraged to do, to accredit their courses as a way to assure members of the public that practitioners have trained properly. Yet, as pointed out by the General Chiropractic Council, "successfully completing a recognised degree programme does not guarantee that someone will become registered as a

chiropractor. It shows us that the applicant has met the degree programme outcomes and so is eligible to apply for registration” (GCC 2012).

Eligibility is the first step as individuals with recognised degrees must then apply to be included on a Council’s register, as the Council not only wants assurance of professional competence (which a degree stands for) but also of an individual’s ethical standing as an applicant must also submit a character reference, “give information about any allegations of professional negligence considered by a civil court” (see Table 2) and declare any criminal convictions. In this way application forms, accreditation reports, recognition visits, interviews and documentation requirements are the micro-components of the technologies of assurance which vouch for certain degree courses or individuals as they generate audit trails which can be checked and verified. Papers must be in order. Yet, the auditing of competence does not always end with registration. As statutorily regulated professionals, osteopaths and chiropractors are required to engage in Continual Professional Development (CPD) and “by 30 November each year registrants must send [the Council] a completed CPD summary sheet, listing learning activities completed, if they wish to remain on the Register for the following year... Registrants must complete 30 hours of CPD each CPD year – 15 hours of this must include learning with others” (GCC 2012; see also Clarke et al. 2004). A Council will usually have an Education Committee responsible for accrediting recognised degrees as well as overseeing continued professional development of members. Such committees assure that both the programmes which lead to qualified practitioner status and the individuals who apply for membership of a register are fit for purpose/practice.

Auditing conduct

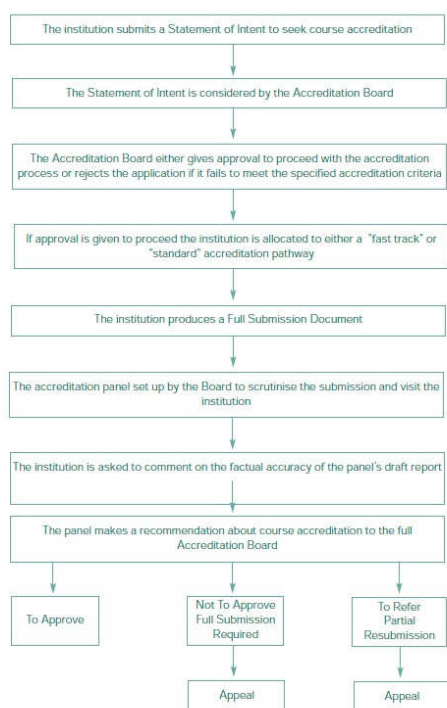
Once certified, members can practice as qualified practitioners of a given CAM therapy. Yet, as discussed earlier, since audited assurance practices are not guarantees, malpractice, misconduct or inappropriate behaviour on the part of a registered practitioner can happen. And as noted in the Chief Medical Officer’s report on “Trust, Assurance and Safety” from 2006, it is in these situations that a Council must act robustly if the confidence of the public is to be maintained. Councils will therefore often include an Investigating Committee, a Professional Conduct and Competence Committee and/or an Ethics Committee. If a complaint is made, the Investigating Committee will make an initial assessment and decide whether the case should be referred to the

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Professional Conduct and Competence Committee who have the power to admonish, impose Conditions of Practice, suspend or strike off a practitioner. Further to the efforts which aim to define the specific competences/qualifications which give an individual access to a particular title discussed above, technologies of assurance also operate through the development and installing of “procedures to protect patients and the public from individuals it deems unfit to practise” (HMRWG 2003: 19). In the words of Professor George Lewith, a long-time advocate of CAM in the UK: “It is the incompetent and the irresponsible we need to stop. Not the well-trained, dedicated herbalists who put their patients first” (cited in BBC 2009).

Table 2: Routes of accreditation and registration

Overview of the Accreditation Process



Applying for GCC registration – Route 1

Check the Register 
Search by name, part of an address or part of a postcode to find a Chiropractor near you.

[Route 1: I have a UK chiropractic degree recognised by the GCC](#)

[What information must I send to the GCC?](#)

[Links to the registration information pack](#)

Route 1: I have a UK chiropractic degree recognised by the GCC

You may apply for GCC registration if you have a UK chiropractic degree recognised for the purposes of registration by the GCC.

If you are not sure whether your qualification is registered please contact our Registration Team: registrations@gcc-uk.org or 020 7713 5155.

What information must I send to the GCC?

As part of your application for GCC registration you must send specific documents, and the registration fee, to the GCC.

Please read the application form through before attempting to complete it. As part of your application you must send us:

1. a completed [application form](#)
2. the registration fee (**Important:** The registration fee is the same at whatever point in the year you join. There is no provision under the GCC rules to allow for pro-rata payments)
3. evidence of your chiropractic qualification recognised by the GCC
4. character reference
5. medical report
6. original Birth Certificate and any other change of name documents (we do not accept copies)
7. copy of the pages from your passport giving your personal details, if you are either a non UK national or hold dual nationality
8. evidence of your professional indemnity insurance for practise in the UK
9. Certificates of good standing from any regulatory bodies with whom you are or have been registered.

These then, are the ways in which the Council as *dispositif* work. Rather than through Draconian measures, paths of accreditation and registration work by educating, persuading, inducing and motivating to shape the conduct of CAM practitioners. Making CAM auditable does not in any way guarantee competent and ethical practice, what it does is makes visible the ways in which

competences of practitioners are vouched for through an assemblage of technologies of assurance – accreditation, registration and disciplining.

Conclusions

The regulation of CAM, it appears, is here to stay. What I have shown in this chapter is how it has become possible to regulate a range of CAM therapies which not too many years ago remained ostracised from any state-sanctioned forms of recognition. This has certainly changed in the last thirty years or so. What I have suggested is that the following conditions can help us account for this change. Firstly, a shift in public protection rationalities in the medical regulation sphere has allowed CAM regulation to replace CAM marginalisation or prohibition as the preferred centralised approach in the UK. This shift, in turn, has been made possible through a tactical separation of practitioner competency from the very contentious question of efficacy.

Notwithstanding unsettled debates about the efficacy of CAM therapies the figure of the ‘qualified and ethically responsible’ CAM practitioner is now feasible. And since we can now speak of a qualified and responsible CAM practitioner, the CAM field has become amenable indeed answerable to the requirements of audit – accountability, transparency, verifiability, etc. In this sense, CAM is no different than the biomedical or banking professions.

Some have suggested that CAM Councils have been modelled on the General Medical Council. While this may be the case, I have argued that we gain more analytical traction from conceptualising the Council as a *dispositif*, an apparatus of assurance which operates through technologies of assurance which vouch for certain activities and/or actions over others. Having been ‘let in’, lawmakers have called on CAM practitioners to ‘put their house in order’ and this is exactly what has characterised the last two decades or so. Vocal critics of CAM regulation remain, and the process has been both polemic and divisive among CAM practitioners. But this has not changed the fact that in an audit society, patients, regulators and health care personnel alike demand assurance that those providing medical care are competent and responsible.

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References

- Adams, Michael (2009) 'Nonsense' alternative medicines should not be regulated', *The Daily Telegraph*, 17 December 2009
- ACHO (2012) "Voluntary Self Regulation – VSR", Affiliation of Crystal Healing Organisations, <http://www.crystal-healing.org/VSR.htm>, accessed on 20 December 2012
- ATCM (2010) "Statutory regulation is the best way to safeguard the public", The Association of Traditional Chinese Medicine's Response to Department of Health Press Release – Next Steps for Complementary Therapy, 1 April 2010, available at: <http://www.atcm.co.uk/>
- BBC (2009) 'Prince's herbal medicine appeal', BBC News, <http://news.bbc.co.uk/go/pr/fr/-/2/hi/health/8388985.stm>, accessed on 29 March 2011
- BMA (1986). *Alternative therapy* London: British Medical Association
- BMA (1993). *Complementary medicine : new approaches to good practice* Oxford: Oxford Univ. Press
- Brown, P.S. (1982). Herbalists and medical botanists in mid-nineteenth-century Britain with special reference to Bristol. *Medical History*, 26(4), : 405-420.
- Brown, P.S. (1985). The vicissitudes of herbalism in late nineteenth- and early twentieth-century Britain. *Medical History*, 29(1), 71-92.
- Bynum, W.F., & Porter, R. (1987). *Medical fringe and medical orthodoxy 1750-1850* London: Croom Helm
- Cant, S. and Sharma, U. (1996) 'Professionalization of complementary medicine in the United Kingdom', *Complementary Therapies in Medicine*, 4: 157-162
- Cant, S., & Sharma, U. (1999). *A new medical pluralism? : alternative medicine, doctors, patients and the state* London: UCL Press
- Clarke, D. B., Doel, M. A., & Segrott, J. (2004) 'No alternative? The regulation and professionalization of complementary and alternative medicine in the United Kingdom', *Health & Place*, 10(4): 329–338
- Clements, A. (Producer) (2007). Slaves to superstition. Enemies of reason. August 20th, London: Channel 4.
- Cohen, M. H. 1998 *Complementary & alternative medicine : legal boundaries and regulatory perspectives*, Baltimore ; London: Johns Hopkins University Press.
- Colquhoun, D. (2009) "Editorial: Secret remedies: 100 years on", *British Medical Journal* 339: b5432
- Colquhoun, D. (2012) "Complementary medicine courses in universities: how I beat the varsity quacks", *The Telegraph*, 31 January 2012, <http://www.telegraph.co.uk/science/science-news/9051103/Complementary-medicine-courses-in-universities-how-I-beat-the-varsity-quacks.html>, accessed on 10 October 2012

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Daily Mail (2010) 'Chinese medicine has caused kidney failure and even cancer. So how safe are these popular 'cures'?', *Daily Mail*, 2 March 2010, <http://www.dailymail.co.uk/health/article-1254746/Chinese-medicine-caused-kidney-failure-cancer-So-safe-popular-cures.html>, accessed on 28 March 2011

Department of Health (2001), Government Response to the House of Lords Select Committee on Science and Technology's Report on Complementary and Alternative Medicine, Presented to Parliament by the Secretary of State for Health By command of Her Majesty, March 2001

Department of Health (2006) *Good doctors, safer patients - Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients - A report by the Chief Medical Officer*, London: COI

Department of Health (2011) Statutory Regulation of Practitioners of Acupuncture, Herbal Medicine, Traditional Chinese Medicine and Other Traditional Medicine Systems Practised in the UK: Analysis Report on the 2009 Consultation

European Parliament (1997). Report on the status of non-conventional medicine by Rapporteur P. Lannoye : A4-0075/97. Brussels: European Parliament.

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. Colin Gordon ed. New York: Pantheon

GCC (2012) "Education", http://www.gcc-uk.org/page.cfm?page_id=25, accessed on 9 January 2013

Great Britain. Parliament (1858) 'An Act to regulate the Qualifications of Practitioners in Medicine and Surgery', CAP. XC: 2 August 1858.

Griggs, B. (1997). *New green pharmacy : the story of western herbal medicine* London: Vermilion

Herbarium (2009) Blog, <http://theherbarium.wordpress.com/2009/02/01/network-of-transition-herbalists/>, accessed on 4 January 2012

House of Lords (1985) Debate on Natural Medicine, 27 February 1985 vol 460 cc970-92

House of Lords (1987) Debate on Complementary Medicine, 11 November 1987 vol 489 cc1379-416

House of Lords (2000) 'Complementary and Alternative Medicine', London: Science and Technology Committee.

HMRWG (2003) 'Recommendations on the Regulation of Herbal Practitioners in the UK: a report from the Herbal Medicine Regulatory Working Group', London: Department of Health, European Herbal Practitioners Association & Prince of Wales's Foundation for Integrated Health

IFR (2012) "Regulation - what is it?", available at <http://www.intfedreflexologists.org/pdf/regulation.pdf>, accessed on 12 January 2013

This paper has been accepted for publication as a chapter in the *Handbook of Complementary and Alternative Medicine*, edited by Nicola Gale & Jean McHale. The final (edited, revised and typeset) version of this paper will be published in the *Handbook of Complementary and Alternative Medicine : Perspectives from Social Science and Law*, by Routledge. All rights reserved. © Taylor and Francis Group

Larkin, G. (1992). *Orthodox and Osteopathic Medicine in the Inter-War Years*. In M.P. Saks (Ed.), *Alternative Medicine in Britain*. Oxford: Clarendon Press

NIMH 2004 'What is herbal medicine?' <http://www.nimh.org.uk/features.html>: accessed on 6 December 2004.

Poling, Samantha (2010) 'Doctors warn over homeopathic 'vaccines'', BBC News Scotland, <http://www.bbc.co.uk/news/uk-scotland-11277990>, accessed on 27 March 2011

PR Newswire (2011) 'Statutory Regulation Best to Safeguard the Public', <http://www.prnewswire.co.uk/cgi/news/release?id=312229>, accessed on 30 March 2011

Power. Michael (1999), *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press

PWFIH (2005) *Complementary Healthcare: a guide for patients*, London: Prince of Wales's Foundation for Integrated Health.

Robbins, Martin (2010) "Quacks fly in all directions as alternative medicine regulation fails", Lay Scientist blog, *The Guardian*, <http://www.guardian.co.uk/science/2010/apr/16/quacks-alternative-medicine-regulation>, accessed on 30 March 2011

Rose, Nikolas (1999) *Powers of freedom*, Cambridge: Cambridge University Press

Rose, N. and Miller, P. 'Political power beyond the state: problematics of government'. *British Journal of Sociology*, 43(2): 172-205.

Saks, M.P. (1995). *Professions and the public interest: medical power, altruism and alternative medicine* London ; New York: Routledge

Saks, M. (1999) 'The wheel turns? Professionalisation and alternative medicine in Britain', *Journal of Interprofessional Care*, 13: 129-138.

Saks, M.P. (2003). *Orthodox and alternative medicine* London: Sage

Save Our Herbs (2012) Myths, <http://www.saveourherbs.org.uk/Myths.html>, accessed on 10 January 2012

Shore, c. and Wright, S. (1999) "Audit Culture and Anthropology: Neo-Liberalism in British Higher Education", *The Journal of the Royal Anthropological Institute*, 5(4): 557-575

Smith, Graeme (2010) 'Editorial: Regulation in complementary and alternative medicine: is it time for statutory regulation of CAM in the UK?', *Journal of Clinical Nursing*, 19(7-8): 901-903

Strathern, M. (ed.) (2000) *Audit Cultures: anthropological studies in accountability, ethics and the academy*, London: Routledge

Thinking is Dangerous (2009) "Department of Health response to CNHC letter", posted on Thinking is Dangerous blog, Thursday, 12 March 2009, <http://thinking-is->

This paper has been accepted for publication as a chapter in the *Handbook of Complementary and Alternative Medicine*, edited by Nicola Gale & Jean McHale. The final (edited, revised and typeset) version of this paper will be published in the *Handbook of Complementary and Alternative Medicine : Perspectives from Social Science and Law*, by Routledge. All rights reserved. © Taylor and Francis Group

dangerous.blogspot.dk/2009/03/department-of-health-response-to-cnhc.html, accessed on 5 December 2012

Tovey, P., Easthope, G. and Adams, J. (Eds.) (2005) *The mainstreaming of complementary and alternative medicine: Studies in social context*, London: Routledge

Toynbee, P. (2008) "Quackery and superstition - available soon on the NHS", *The Guardian*, 8 January 2008

Veitch, A. (1986) "BMA's wounding verdict on rival healers / Alternative medicine dismissed as ineffective", *The Guardian*, 13 May 1986

Wahlberg, A. (2007) "A quackery with a difference – new medical pluralism and the problem of 'dangerous practitioners' in the United Kingdom", *Social Science & Medicine*, 65(11): 2307-16

Wallis, R., & Morley, P. (1976). *Marginal medicine* London: Owen

Welsh, S., Kelner, M., Wellman, B. and Boon, H. (2004) 'Moving forward? Complementary and alternative practitioners seeking self regulation', *Sociology of Health and Illness*, 26: 216-241

Westcott, P (1992) "New code of conduct for safe alternatives", *Daily Mail*, 16 June 1992

This paper has been accepted for publication as a chapter in the *Handbook of Complementary and Alternative Medicine*, edited by Nicola Gale & Jean McHale. The final (edited, revised and typeset) version of this paper will be published in the *Handbook of Complementary and Alternative Medicine : Perspectives from Social Science and Law*, by Routledge. All rights reserved. © Taylor and Francis Group

Box 1: Regulating CAM practice in the UK – some milestones

September 1982 – the Institute for Complementary Medicine is formed “to provide the public with information on all aspects of the safe and best practice of Complementary Medicine through its practitioners, courses and research”.

February 1985 – the Council for Complementary and Alternative Medicine is launched by former Prime Minister Lord Home as “the first national association of professional bodies of complementary and alternative medicine that have substantial training and comprehensive codes of ethics and practice”

May 1986 – the Board of Science Working Party on Alternative Therapy of the British Medical Association (BMA) publishes its report *Alternative Therapy* suggesting that “growing interest in complementary medicine” is a “passing fashion”, citing their duty to warn patients “that consultation with practitioners of some alternative therapies may be attended by the risk of great harm” (BMA 1986: 1, 73-4).

June 1992 - the British Complementary Medicine Association formed “to help protect the public by maintaining a register of suitably qualified practitioners of Complementary Medicine”

July 1993 – the Osteopaths Act is passed leading to the formation of the General Osteopathic Council with a remit “to protect the public and maintain the reputation of the profession”.

July 1993 – the BMA changes tactics calling for “good practice” in the CAM field in their report *Complementary medicine: new approaches to good practice* arguing that “doctors have a duty to... safeguard the public health and, to this end, it is important that patients are protected against unskilled or unscrupulous practitioners of health care” (British Medical Association 1993: 2).

July 1994 – the Chiropractors Act is passed leading to the formation of the General Chiropractic Council with a remit “to protect the public by establishing and operating a scheme of statutory regulation for chiropractors, similar to the arrangements that cover other health professionals”

April 1996 – Department of Health-commissioned report *The Regulation of Health Professions: a review of the Professions Supplementary to Medicine Act (1960)* suggests that “Statutory regulation is the route through which the ‘newly emerging’ professions or alternative/complementary medical professions are seeking regulation”

January 1997 - Department of Health publishes commissioned report *Professional organisation of complementary and alternative medicine in the United Kingdom* “to throw light on approaches towards coordinating activity and encouraging responsible practice”

November 2000 – the House of Lords Select Committee on Science and Technology publishes landmark report *Complementary and Alternative Medicine* arguing that “the use of complementary and alternative medicine (CAM) is widespread and increasing across the developed world... rais[ing] significant issues of public health policy such as whether good structures of regulation to protect the public are in place”. Acupuncture and herbal medicine are singled out as “two therapies which are at a stage where it would be of benefit to them and their patients if the practitioners strive for statutory regulation”.

March 2001 – Department of Health publishes the Government’s response to the House of Lords report concurring that “it would be desirable to bring both acupuncture and herbal medicine within a statutory framework as soon as practicable”. They also suggest that “the Government is prepared to consider the possibility of extending statutory regulation for other therapies if there is a case for it, and there is a unified professional body which has the support of most members of its profession for pursuing that option”. As a minimum “the Government... strongly encourages the regulating bodies within each therapy to unite to form a single body to regulate each profession”.

January 2002 – Herbal Medicine Regulatory Working Group formed to “support and promote moves towards unification within a federal structure of the herbal practitioner profession”.

September 2002 – Acupuncture Regulatory Working Group (ARWG) formed

2005 – the Department of Health pledges £900,000 to the Prince of Wales Foundation of Integrated Health to advance work on the regulation of CAM practitioners.

September 2005 – Publication of the Stone report which makes proposals for a federal voluntary regulatory structure for complementary healthcare professions. The report was commissioned by the Prince of Wales's Foundation for Integrated Health. The Foundation also publishes *Complementary Healthcare: a guide for patients* “to give you enough information to help you choose a complementary therapy that is right for you and find a properly trained and qualified practitioner of that therapy.”

2007 – Professor Dame Joan Higgins chairs the Federal Working Group (FWG) to follow up on the Stone report proposals, eventually leading to the launching of the Complementary and Natural Healthcare Council (CNHC).

October 2007 – the General Regulatory Council for Complementary Therapists (GRCCT) is launched

April 2008 – the Complementary & Natural Healthcare Council (CNHC) is set up.